HEADQUARTERS AIR FORCE PERSONNEL CENTER

Randolph Air Force Base, Texas

The MEB Process

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Welcome!

This presentation is intended primarily for PEBLOs, but anyone, to include medical providers, can benefit, especially from the later sections. This info is intended to supplement the AFIs, not replace them, and it cannot take the place of first-hand teaching by an experienced mentor.

There are quizzes at the end of each major section. The answer slide follows each quiz slide.

Review this slide show at your convenience. You may find it easier to do one section and come back later to do the others. However it works for you. There is no requirement to "pass" this training – it is merely to help everyone out there do their jobs better and understand the MEB process a bit better.

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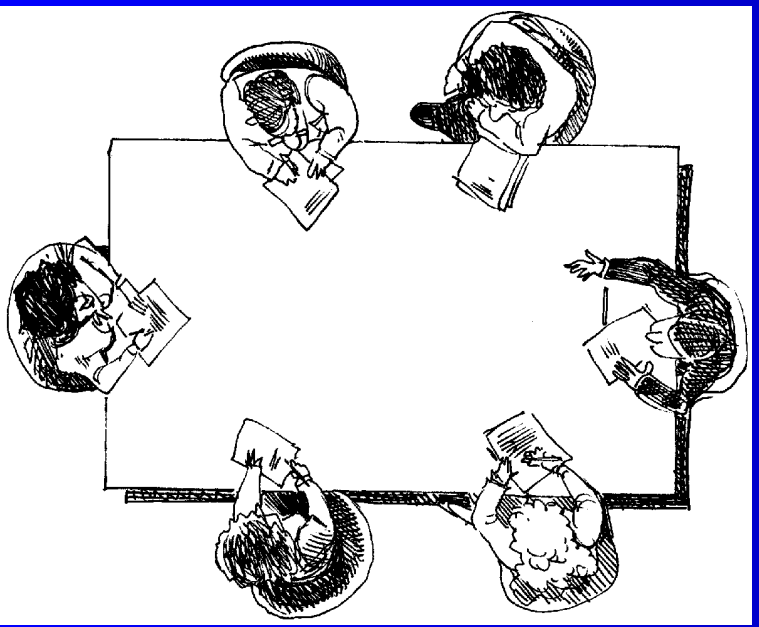
Overview

- Medical Evaluation Board (MEB)
- PEBLO Responsibilities
- MEB Procedures
- Assignment Limitation Code C
- Review in Lieu of (RILO) MEB
- Medical Hold
- Elective Surgery

The Medical Evaluation Board



Definitions

- Medical Evaluation Board (MEB) can have two meanings:
- 1) the *process* by which members who have certain medical conditions are evaluated for continued fitness for duty
- 2) the three-physician *entity* which meets at the base clinic/hospital to make the first-level recommendation about member's fitness

Governing AFIs

- Primary AFIs
  - 44-157 (spells out details of MEB process)
    - Now superseded by 41-210, Ch. 10, but no real changes
  - 48-123, Attach 2 (spells out who needs MEB)
  - 36-3212 (Physical Disability Evaluation)
- Other AFIs
  - 36-3208 (Admin Separations)
  - 36-2910 (Line of Duty)
  - 36-2110 (Assignments)
- Know the primary ones *cold;* be *aware* of others

Who Needs an MEB?

- Any AF member with a disqualifying condition noted in AFI 48-123 (Attach 2)
- Any member with a condition which provider feels is unacceptable for continued military service, even if not listed in AFI
- Any member with a special situation found in AFI 48-123, section A2.21
- Members w/ *unsuiting conditions* (those in DoDI 1332.38 Encl. 5, or AFI 36-3208 sec. 5.11) *don't* need MEB
- Members in confinement or under Court-Martial charges are *not eligible!*

Flow of MEBs at MTF Level

- Provider dictates MEB narrative
- PEBLO puts together MEB package
- Three *physicians* (the actual MEB board) review package, make disposition recommendation
  - Must be either “Return to Duty” or “Refer to IPEB”
- MTF/CC or designee (must be physician), signs the MEB package as the Approval Authority
- *Final* signature is member’s (NOK if incompetent)
- PEBLO forwards package to AFPC

Sending MEBs to AFPC

- *ALL* "Return to Duty" MEBs come to DPAMM (Medical Standards)
  - If DPAMM concurs, we return member to duty, with or without a C-Code (see later section)
  - If DPAMM non-concurs, we send case to IPEB
- "Refer to IPEB" cases from designated PEB Referral Hospitals (see 44-157 para 3.5) go directly to IPEB
- "Refer to IPEB" cases from *non*-PEBRHs (most AF clinics) come to DPAMM first; if they are complete, we then send them to IPEB

Getting Cases Back from AFPC

- You may get cases back from AFPC for one of three reasons:
  - Case incomplete, needs more information
  - Case adjudicated, member discharged
  - Case adjudicated, member returned to duty
- See next three slides for details

Cases Returned for More Info

- Either DPAMM or IPEB may request more info
- Some of the *many* reasons:
  - AF 618 or narrative >30 days old, consults >90 days
  - AF 618 missing vital info like dates, etc.
  - No Line of Duty (AF 348) in cases involving injury
  - Missing key items (CC letter, AF 422, SF 88/93, etc)
- Suspense firm: if missed, entire case returned – take it seriously!

Cases Where Member Discharged

- In this case, IPEB will send message directly to PEBLO
- PEBLO then counsels member on decision, time course for discharge, and member's rights to appeal
- Counsel IAW AFI 36-3212, Attachment 2, "Counseling the Evaluee"

Cases Where Member Returned to Duty

- If member returned to duty (either by IPEB or by DPAMM), case goes to DPAMM
- DPAMM decides if Code C warranted
- DPAMM then sends “Form 4” to PEBLO
- Form 4 gives instructions for disposition
  - Return to duty (RTD), profile accordingly
  - RTD with Assignment Limitation Code C
  - Case doesn’t fall under Disability; process under other AFIs
  - Not ready to board yet; continue care, board later

Turnaround Time for MEBs

- Cases sent to AFPC with “Return to Duty” recommendation by MEB:
  - Generally a few days to a week
- Cases sent to AFPC with “Refer to IPEB” recommendation by MEB:
  - Generally a few weeks to a month
- Of course, if member found unfit but chooses to appeal, process can drag on for many months

MEBs - Quiz

- T/F: If a member has a condition not found in AFI 48-123, he doesn't need an MEB
- T/F: Those with alcoholism or Attention Deficit Disorder need an MEB
- T/F: PEB Referral Hospitals refer all of their MEB cases directly to the Informal PEB
- T/F: Cases sent to AFPC always take a few months to return a verdict
- T/F: Members under Court-Martial charges cannot have an MEB

Quiz Answers

- False. Any condition, if felt to render member unfit, can be boarded
- False. Those conditions are *unsuiting* per DoDI 1332.38, Enclosure 5 (read this one!)
- False. Even direct Referral Hospitals send their MEBs marked “Return to Duty” to DPAMM
- False. Cases, assuming they are complete, marked “RTD” usually take only a few days, while cases marked “IPEB” usually take less than a month
- True. Same with those in confinement

PEBLO Responsibilities

PEBLO Responsibilities

- Counsels members about MEB/PEB process when they enter Disability system
- Notify member's CC about MEB; ensure CC knows not to allow member to go on leave or TDY during processing
- Keeps MEB process on track and on time
- Ensures quality of MEB package
- Maintains communication between member, MTF, MPF, and AFPC
- Counsels member when decision returned
- Ensures each PEBLO is designated in writing by MDG/CC; copy of "orders" to DPAMM/DPPDS

PEBLO Responsibilities: Putting Together MEB Package

- Ensure 4T/Code 37/C-Code updated if necessary
- Check Separation/Retirement Date
- Decide if Line of Duty needed; initiate it
- Put together AF 618 and get signatures
- Get Commander's Letter, narrative summary, and all other required documents – *hound* if necessary
- Involve SGH if doc/member/CC/etc uncooperative
- Put case together in *coherent* order
- Send original and 3 copies to AFPC, keep 1 copy
- Maintain "tickler file" so you know if a case is overdue and you can call AFPC if no word in a reasonable time

MEB Procedures

Required Documents

- AF 618 Cover Sheet, <30 days old
- AF 1185
- Commander's letter, signed by *officer*
- Narrative Summary, <30 days old
- Specialty consults; generally <90 days old
- SF 88/93 (or sub) from entry on active duty
- Current AF 422 Profile, w/duty limitations
- Admin LOD, either on narrative or AF 618

Documents Sometimes Necessary

- Line of Duty on AF 348 (*all* injury cases)
- Statement by Reserve SG (Reserve cases)
- Unless "permanently" activated, *ALL* Guard/Reserve cases *require*:
  - LOD on AF 348 for *each* injury ***or illness***
  - Copy of orders to Active Duty at time of diagnosis
  - Full outpatient medical record
- Member's Letter of Exception (if desired)
- Statement of credentials or AF 2499 (for providers)
- Copy of DPAMM's waiver to conduct MEB locally (if MEB is on an officer assigned to MTF)

AF 618 Specifics

- DO NOT USE WHITE-OUT! (Legal doc.)
- Do not leave blanks unless not applicable
- Dates: complete blocks 2, 28a, and 29a
  - Missing dates most common AF 618 mistake
  - Must be in order; 29a cannot precede 2 or 28a
- Gulf War Statement no longer required
- Recommendation (block 25) – don’t omit!
  - Must be either Return to Duty or Refer to IPEB

AF 618 Specifics (cont.)

- Diagnosis (block 23a)
  - Must agree w/ diagnoses on narrative summary
  - List all *boardable* diagnoses (AFI 48-123, attach 2)
  - *Don't* list diagnoses which *don't* require MEB
  - If you list a diagnosis, it *must* be addressed in narrative

- Existed Prior to Service (EPTS) (23c-23f)
  - Fill out these blocks for *each* diagnosis
  - If narrative says condition was EPTS, make *sure* blocks 23d and 23e are checked, *not* 23c or 23f!
  - If condition *not* EPTS, then check 23c and 23f
  - If EPTS, LOD finding must be "LOD N/A – EPTS"
    - Ensure that LOD does not say "yes" on either narrative or 618!

AF 618 Specifics (cont.)

- Board Signatures (blocks 26 and 28)
  - *MUST be physicians*
  - A maximum of one of the four signatures may be from a civilian physician w/some sort of staff privileges
  - A *psychiatrist* must sign all psychiatric MEBs
- Member Signature (block 29)
  - If member incompetent, NOK is counseled and signs
  - If member refuses to sign, document that member was *counseled on process* (critical) and refuses to sign; PEBLO then signs and forwards to AFPC

Line of Duty

- No case can be processed without a Line of Duty!
- Primary governing AFI: 36-2910
- A LOD determination is done to ensure that a disability was not incurred as a result of the member's own misconduct, and was not incurred while member AWOL
- An Administrative LOD is appropriate for all cases except injury and ANG/Reserve cases
  - Physician decides this
  - Must be annotated *either* on AF 618 *or* in narrative
- LOD on AF 348 *required* for all injuries and all ANG/Reserve cases (unless "permanently" activated)
  - Physician initiates, then unit CC and JAG complete
  - Ensure that both CC and JAG sign, and check correct boxes
  - Ensure that both FRONT and BACK of form are sent to AFPC!

LOD and EPTS

- If a condition existed prior to service (EPTS), then in general, the finding is "LOD N/A – EPTS."
- Ensure this is on AF 618 and/or narrative
- Do not say EPTS on 618 and/or narrative, then annotate "LOD – Yes" on either form
  - This is a contradiction of terms!

Narrative Summary

- AFI 41-210, section 10.6.1, gives fabulous detail about what *MUST* be in a Narrative Summary
  - May wish to print out for each of your PCMs
- Must be <30 days old when received at AFPC
- Must be signed/co-signed by a physician
- Psych narratives (AFI 41-210, section 10.6.10.14)
  - Must provide five-axis diagnosis, no axis deferred
  - Include *both* S/I Impairment *and* Military Impairment
  - Must be signed/cosigned by a psychiatrist, *not* just a psychologist

MEB Procedures - Quiz

- T/F: AF 618 and 1185, narrative, consults, CC letter, SF 88/93, and AF 422 are the only documents required for MEB packages
- T/F: White-out is acceptable on AF 618
- The most common mistake on AF 618 is (fill in the blank).
- T/F: A Line of Duty is necessary only if there is an injury
- T/F: A psychologist must sign AF 618 in all psychiatric cases

Quiz Answers

- False. Many other documents may be required depending on various factors
- False. AF 618 is a legal document
- Most common AF 618 mistake is omitted data, especially dates
- False. LOD on AF 348 is necessary in all injury cases and almost all ANG/Reserve cases, but admin LOD req'd on ***all*** cases
- False. A psychologist is a BSC, not a physician. **Only** physicians may sign AF 618. A psychiatrist must sign AF 618 on all psychiatric cases

Assignment Limitation Code C

Assignment Limitation Code C (ALC-C)

- Limits assignments to CONUS, Hawaii, Alaska (Elmendorf) and Puerto Rico
- Placed *ONLY* by AFPC/DPAMM (Medical Standards) after member has been returned to duty by the Air Force Disability System
- Can *ONLY* be lifted/removed by DPAMM

ALC-C (cont)

- Usually a permanent code for chronic illnesses
- May be removed under certain conditions
  - Cancer codes usually only for a few years
  - Occasionally can remove code for non-cancer illnesses but very rare, requires high-level review, not easy!
- Can *ONLY* be lifted/removed by DPAMM

ALC-C (cont)

- Members with C-Codes require review every 1-2 years depending on condition
- Review-in-Lieu-of MEB (RILO) is mechanism for periodic review
- DPAMM will specify frequency of RILOs, and whether specialty consultation required
- See next section for details on RILOs

ALC-C (cont)

- Any time a member's condition changes, and provider or commander feels that member is no longer fit for duty, PCM or specialist can submit RILO early
- Include all the details about how member's condition has changed
- DPAMM will determine if full repeat MEB is warranted

What Conditions Get ALC-C?

- **NOT Every Condition Gets ALC-C!!!**
- List of “C-Codable Offenses” comes from Surgeon General’s office
- If condition is not on that list, it doesn’t get an ALC-C, even if it seems like it should
  - Example – there are *no* orthopedic C-Codes
- If member returned to duty with no C-Code, MANAGE CONDITION WITH PROFILES!

Waivers of ALC-C

- Members on ALC-C *may* be eligible for overseas TDY or even PCS
- AFI 41-210, para 10.8.3, is waiver authority
- Submit waiver request letter to DPAMM
- Requests *MUST* meet *every* criteria in AFI
- DPAMM is final (only) approving authority

Waivers of ALC-C

- Waiver request must:
  - Be endorsed by General Officer or Wing/CC who is aware of the member's medical condition
- And state that:
  - Member is best one qualified and available
  - Member is mission essential
  - Member is not going to a mobility position
  - Adequate medical care has been coordinated with gaining medical facility commander

ALC-C Quiz

- T/F: ALC-C prevents PCS moves overseas but allows TDYs to large facilities overseas
- T/F: ALC-C can be removed by the SGH if he/she conducts a thorough evaluation
- T/F: If a member's C-Coded condition worsens, PCM must wait until the annual RILO to report those changes to AFPC
- T/F: Any member who is returned to duty by the Disability system will get an ALC-C
- T/F: Those with ALC-C can never go overseas for any reason to any base for any length of time

Quiz Answers

- False. ALC-C prevents *all* travel overseas except to Hickam or Elmendorf, unless a waiver is granted
- False. ALC-C can ***only*** be removed by DPAMM!
- False. Any time a member's condition worsens, PCM can submit a new RILO to see if member still fit for duty
- False. Many conditions (e.g., back pain) have no ALC-C and must be managed with profiles
- False. AFI 41-210, para 10.8.3, specifies the rules for TDY or PCS moves overseas under certain conditions. DPAMM is the ***only*** approval authority!

Review-in-Lieu-of MEB (RILO)

Review in Lieu of (RILO) MEB

- RILO is basically a narrative summary
  - Does not need to be very long
  - Should have enough data (present illness, brief past history) to act as a stand-alone document
  - *MUST* describe member's current condition, including meds, labs/PFTs (if applicable), further treatments planned, and prognosis
  - Include current specialty consults if required
  - Submit by fax to DPAMM, at DSN 665-2354

Uses of RILO

- Annual review of those on C-Code
  - Ensures member still fit for duty
  - If condition worse, DPAMM directs full repeat MEB
- Query into whether a condition needs full MEB
  - Done when need for MEB is questionable
  - A call from attending physician does the same thing!
- Conditions discovered within 60 days of retirement, separation, PCS, or deployment
  - In this case, DPAMM can adjudicate RILO as if it were a full MEB (gets member back to duty expeditiously, if appropriate)
  - If, however, member cannot do his/her job or has a condition which might require medical separation, DPAMM will request a full MEB package and will put Ret/Sep/PCS/TDY on hold

RILO -- Quiz

- T/F: A RILO need only be a few sentences, and it may say “see prior MEB for details”
- T/F: A RILO is just a simple narrative and never needs consults, labs, or other tests
- T/F: A RILO can substitute for a full MEB any time it is convenient
- T/F: Those on C-Codes require a full MEB every year

Quiz Answers

- False. A RILO must have enough details to act as a “stand-alone” document.
- False. A RILO must contain not only a brief narrative, but also any consults, labs, or tests which are pertinent.
- False. A RILO can only substitute for an MEB when the member is within 60 days of a PCS/DOS/DOR/etc, and even then, only if DPAMM agrees that member is still fit for duty.
- False. Those on C-Code require a RILO annually, and need an MEB only if directed by DPAMM.

Medical Hold

Medical Hold

- Used to retain members beyond established date of separation or retirement
- HQ AFPC/DPAMM is sole authority for approval and removal (for active duty AF)
- References:
  - AFI 48-123, Chapter 6
  - AFI 41-210, Section 10.7.11

Medical Hold -- Uses

- Used when a catastrophic condition occurs shortly before retirement/separation
  - Threat to life/limb/eyesight (cancer, injury, etc)
- Used to complete disability processing for conditions which render member unable to do his/her job
  - If member **HAS** been able to do job, a RILO can be done in one day; member returned to duty under Presumption of Fitness (see next slide) and no Medical Hold is necessary

Duration of Medical Hold

- Medical Hold is not used to complete treatment or “fix” member’s condition
- It is used to get the member out of danger, or to complete disability processing
- DPAMM will grant Med Hold for the time it takes to get member out of danger, and to do either a RILO or MEB, plus MEB processing time
- Long-term follow-up, or rehabilitation, may be done at VA if member not medically retired, or at military or TriCare facilities if medically retired

Medical Hold and the Presumption of Fitness

- "The existence of a … condition does not in itself necessarily provide justification for or entitlement to an MEB. The law that provides for military disability … is not used to bestow additional benefits upon those approaching retirement or separation. If a member has performed his or her duty satisfactorily prior to … retirement or … separation … , a presumption of fitness is established." (AFI 41-210, para. 10.1.3)
- Bottom line: we do not place people on Med Hold unless they overcome the presumption of fitness

Medical Hold Is NOT Used for:

- Evaluating and treating chronic conditions
- Performing diagnostic studies
- Elective surgery OR its convalescence
- Conditions which don't overcome Presumption of Fitness (see prior slide)
- Preservation of Terminal Leave
- Those being involuntarily separated
- Those whose date of sep/retirement already past

Medical Hold

- Can only be approved when member is within 60 days of separation or retirement – not before!
- Enlisted members may decline Med Hold; should consent in writing if they accept
- Officers serve at the discretion of the president and cannot refuse Medical Hold
- Member must be at work while on Medical Hold, unless he/she is too sick to work – cannot be on Terminal Leave or otherwise staying home!

Obtaining Medical Hold

- Only done by physician to physician consult
  - PEBLOs, members, and commanders may not request Med Hold
- Call to AFPC/DPAMM
  - DSN 665-3580
- Technician will take dem graphic info then conne with Chief of DPAMM

Medical Hold Responsibilities

- Members on Medical Hold receive full pay and benefits at taxpayer expense!
- At the time Med Hold is granted, DPAMM will suspense either a RILO or a full MEB
- Everyone MUST expedite MEB processing to avoid long stays on Medical Hold
- Physicians should personally call consultants to expedite patient appointments
- Providers should dictate RILO or MEB ASAP
- Suspences are firm. PEBLOs should ensure packages get to AFPC, with all needed info, quickly. TIME IS OF THE ESSENCE!!

Medical Hold for Guard/Reserve

- If Guard/Reservist is retiring or separating from Guard/Reserve, then DPAMM is approval authority (DSN 665-3580)
- If Guard/Reservist is demobilizing from Activated status back to Guard/Reserve status, then ANG/SGP or Reserve/SGP is approval authority
  - ANG – DSN 278-8552/8936
  - AFRC – DSN 497-0603 (Reservists in Reserve units)
  - ARPC – DSN 926-7236/7237 (IMA Reservists)
- If in doubt, call Guard/Reserve folks FIRST

Medical Hold -- Quiz

- T/F: *Either* the member's commander *or* the MPF can approve Med Hold
- T/F: All members are entitled to Med Hold to work up all conditions noted at retirement physical
- T/F: Members with cancer can be kept on Med Hold for up to a year, to complete all treatment
- T/F: Med Hold can be used for elective surgery and/or to preserve member's terminal leave
- T/F: *Either* PEBLOs *or* commanders may call DPAMM to request Med Hold

Quiz Answers

- False. Only DPAMM approves Med Hold.
- False. Only used for recent, major illnesses, or for conditions which truly interfered with duty.
- False. Members are kept on Med Hold long enough to get them out of danger and/or get MEB processed, not to complete treatment.
- False. Cannot be used for these things, *or* for chronic conditions, diagnostic workups.
- False. Only medical providers may request Med Hold.

Elective Surgery

Elective Surgery

- Defined as surgery *not* necessary to save life, limb, or eyesight
  - Not the same as cosmetic surgery
  - Just means it's not urgent – it can safely wait
- *Cannot* be done within six months of separation or retirement without DPAMM's prior approval

Elective Surgery -- Mechanism

- Military provider must call DPAMM at DSN 665-3580 or 665-2679
- May be surgeon (if he/she is military) *or* PCM (if specialist is not military)
- DPAMM techs will take demographic info, then put provider through to DPAMM physician to discuss the medical aspects
- Member/commander/PEBLO may *not* call!

Elective Surgery – Required Info

- Demographics (name, SSN, date of ret/sep)
- Proposed procedure *and date of surgery*
- Surgeon's estimate of how long it will take for member to:
  - ambulate independently
  - do activities of daily living (ADLs) unassisted
  - drive a car independently
  - sit at a desk and do an admin job

Elective Surgery: Approval Policy

- No specific guidance in AFI 48-123, para 5.5.4, so DPAMM has created own policy
- Take surgeon's estimate of time required to regain reasonable function (see previous slide)
- *Double this* to allow for complications
- If doubled recovery time still within member's remaining time till retirement or separation, it's approved. Otherwise, it's disapproved.

Elective Surgery – Approval Policy Rationale

- Concrete – eliminates subjectivity
  - Keeps DPAMM from deciding who's worthy
  - Keeps DPAMM from deciding what's worthy
- Reproducible – eliminates variability among adjudicators
- Safe – doubling of recovery time to allow for complications ensures troop is functional on date of retirement/separation

Elective Surgery – Why Is Approval Needed?

- AFI 48-123, para 6.4, states that Medical Hold may not be used for "elective surgery or its convalescence." Thus, DPAMM *cannot* place people on Med Hold to recover from an elective surgery done too close to separation or retirement
- People do not like retiring or separating from their hospital bed!
- DPAMM oversight ensures a reproducible policy is in place to ensure equitable decisions AF-wide

Elective Surgery – Formal Approval

- Member must sign written acknowledgment that he/she will not be kept on Med Hold for recovery or complications of the surgery, or to preserve his/her terminal leave
- DPAMM can email or fax this document to you
- Form *must* be faxed back to DPAMM at DSN 665-2354
- If surgery must be delayed past the approved date of procedure, DPAMM must re-approve it!

Elective Surgery – Options if DPAMM Disapproves It

- Member can re-enlist or request that retirement date be moved back (not a given)
- Member can have surgery done at MTF as a retiree
- Member can have surgery done at VA if member is separating

Elective Surgery -- Quiz

- T/F: An emergency appendectomy 3 days before separation must be pre-approved by DPAMM
- T/F: Prior to elective surgery, the member must call DPAMM for approval
- T/F: If the member won't be able to walk for 6 weeks post-op, but has 7 weeks left before separation, DPAMM will approve the surgery
- T/F: If an elective surgery goes bad, you can always get Med Hold to let the member recover
- T/F: No paperwork is required for Elective Surgery – it's all done by telephone

Quiz Answers

- False. Pre-approval is for *elective* surgeries.
- False. Only the *patient's provider* can request elective surgeries.
- False. DPAMM *doubles* the recovery period to allow for complications.
- False. Med Hold is not authorized for recovery from elective surgery.
- False. Member must sign elective surgery request letter as part of the approval process.

Congratulations! You've finished! Sorry that I don't know how to make this thing print out certificates….

Best Wishes. If we can help, don't hesitate to call us at DSN 665-3580/2679/2335.

---------The Staff of Medical Standards---------